HealthPlans
A HARVARD PILGRIM COMPANY

# Claim Form – Flexible Spending Account

*Use this form to submit for reimbursement of eligible medical, dental, vision, and dependent care expenses.*

| | | | |
|---|---|---|---|
| Employer/Company Name | Department/Division | Health Plans Member ID# | |
| Employee Last Name | Employee First Name (Subscriber) | M.I. | DOB (MM / DD / YYYY) |
| Street Address | City | State | ZIP Code |
| Email Address | ( ) Home Phone Number | ( ) Work / Mobile Phone Number | |

## Instructions

For reimbursable expenses that were part of a medical or dental claim, attach copies of insurance plan claim and/or payment forms (to establish amounts not paid under the insurance plan).

For all other reimbursable expenses (including Dependent Care expenses if you have enrolled in that option), attach copies of all invoices/receipts, which must include the following:

- the date(s) of service
- the name and address of the provider who provided the service
- the reason for the charge (i.e., the nature of the service)
- the member for whom the services were provided
- the amount of the charges

| Date of Service | Name of Service Provider | Describe Expense | Member Name | Net Amount |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | TOTAL FROM PAGE 2 | $ 0.00 |
| | | | CLAIM TOTAL | $ 0.00 |

## Please Read Carefully

The undersigned Plan Participant (Subscriber) certifies that all expenses claimed herein were incurred during a period of active coverage. The undersigned understands that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information contained herein, and that if an expense claimed herein is not an eligible expense under the plan, the undersigned may be liable for the payment of all related taxes (including federal, state, or city income tax) on amounts paid by the plan which relate to said expense.

I certify that all items claimed herein comply with the Flexible Spending Account program, and said items have not and will not be covered by any other plan or program of any employer, or other party, and will not be reimbursed through a rebate program.

Employee Signature ***(required)*** Date

**Print and submit this form to:**

**Health Plans, Inc.**
Attn: Flexible Spending Dept.
PO Box 5199
Westborough, MA 01581

**or fax to: 508-329-4815**

***Please retain a copy of this form and all related documentation for your records.***

*Questions? Please call **800-343-7674, ext. 8416**, or submit your question online at **www.healthplansinc.com**, and click on **Contact Us**.*

*rev. 5/9/2011*

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Subscriber Name _____ Health Plans Member ID# _____

| Date of Service | Name of Service Provider | Describe Expense | Member Name | Net Amount |
|---|---|---|---|---|
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**PAGE 2 TOTAL** $ 0.00

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